Health Claim Transmittal



A. GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Please clip (do not staple) all bills to the completed from and mail them to UnitedHealthcare at the address listed on your ID card.
- Please make sure all bills include a diagnosis code, procedure code, date of service, place of service, and cost.
- Please submit all claims to UnitedHealthcare in a timely manner.
- Please notify your employer of address changes.

Please include your Subscriber Number or Social Security Number on all documents. SUBSCRIBED (TARRED VEG INFORMATION)									
B. SUBSCRIBER/EMPLOYEE INFORMATION Subscriber # or SSN: – –						Phone # ()			
						,			
Employer Name:						Group Number (on ID card):			
Last Name: First Na			Name:		MI:		Date of Birth: / /		
Home Address:								New Address? Yes No	
City:						State:		ZIP Code:	
Spouse Last Name:			First Name:			MI:		Spouse Date of Birth	
C. PATIENT INFORMATION (if different from Subscriber/Employee)									
Subscriber # or SSN: – –						Phone #: ()			
Last Name: First N			rst Na	Name:		MI:		Date of Birth: / /	
Home Address:								New	
City:				C+		State:		Address? Yes No ZIP Code:	
				T - 11 - 1 - 1 - 1		-		en couc	
					School Name:			School Phone:	
D. ACCIDENT INFORMATION									
Work Accident: Yes □ No□ Auto Accident: Yes □ No□ Other: Yes □ No□ Date of Accident: / /									
How did the accident happen?									
E. OTHER INSURANCE									
Is the patient covered by another insurance plan? Yes No No If yes, please complete the following information.									
Name of person carrying other insurance:						Date of Birth: / /			
SSN: – – Name of Other Insur					Other Insurar	nce Carrier:			
Policy Number: Employer Name:					Name:				
ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE,									
INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE									
			SU	BJECT TO CI	VIL PENALTII	ES.			
Signature						Date (mm/dd/yyyy)			
F. Assignment of Benefits									
Please sign below only if you want UnitedHealthcare to pay benefits directly to the provider of medical services.									
Cianat.				_		-	D-1 /	/ -1 1 /	-
Signature Date (mm/dd/yyyy)									